Paramedic License Renewal Application

Idaho Emergency Medical Services Bureau

Send completed form to Idaho EMS Bureau, PO Box 83720, Boise, ID 83720-0036 or Fax to 208-334-4015

Completion checklist: ☐ Application ☐ License Holder Signature ☐ Affiliating Agency Authorized Signature ☐ Skills verification completed and signed

☐ Completed continuing education record ☐ $25 renewal fee: check enclosed ___ or direct bill my Agency_____

Name _____
Last Name First Name Middle Name/Initial

Idaho EMS License # _____ or Social Security # if you don't know your Idaho EMS License number ___ - ___ - ____

Circle the highest level of education: GED High School Diploma College: 1 2 3 4 5 6 7 8 Gender ☐ F ☐ M

Home Phone # _____ Work Phone # _____ Cell Phone #_____

E-Mail Address _____

Mailing Address _____
Street City State Zip County

Affiliation:

Qualifying Agency of Affiliation _____ Agency License # _____

Agency Authorized Signature _____ _____
Signature Printed Name

Career status for qualifying agency: ***Volunteer*** ☐ True ☐ Compensated ***Career*** ☐ Full Time ☐ Part Time

List all agency or hospital affiliations or associations (Use additional form if necessary.)

Agency/Hospital _____ ***Volunteer*** ☐ True ☐ Compensated ***Career*** ☐ Full Time ☐ Part Time

Agency/Hospital _____ ***Volunteer*** ☐ True ☐ Compensated ***Career*** ☐ Full Time ☐ Part Time

Agency/Hospital _____ ***Volunteer*** ☐ True ☐ Compensated ***Career*** ☐ Full Time ☐ Part Time

I am also an Idaho licensed/certified health care provider as a(n) (circle all that apply): MD / DO / PA / RN / RT / other (please specify) _____

Have you been charged with or convicted of a felony that you have not previously disclosed to the EMS Bureau? ☐ Yes ☐ No

If yes please explain:_____

Has an EMS agency taken any adverse action against you that you have not previously disclosed to the EMS Bureau? ☐ Yes ☐ No

If yes, please explain: _____

(Separate sheets may be attached)

Signature:

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS licensure as established by the State of Idaho.

Signature of Candidate _____ Date signed _____

For Bureau Use Only

Received in Bureau	Cert. Fee Rcvd Date _____ ☐ Cash – Receipt # _____ ☐ Check # _____ ☐ M.O. # _____ ☐ DB - Agency _____

Paramedic License Renewal Education Record Candidate Name: _____

Each license cycle, a Paramedic must complete:

-A minimum of 72 hours of continuing education (CE)
-A minimum of six (6) venues
-A minimum thirteen (13) categories
- Pediatric assessment and management must be one of the categories with a minimum of eight (8) hours
- EMS Systems and Operations must be one the categories with a minimum of three (3) hours, including an LZO and extrication awareness course
- Must have a minimum of four (4) hours in any 11 of the remaining categories

-Remaining hours can be completed in any combination of categories and venues

Categories (below)	**Venues**										**TOTAL hours in each Category** (add across)
	Structured classroom sessions	Refresher programs that revisit original curriculum and have an evaluation component	Nationally recognized courses	Regional and national conferences	Teaching topical material	Agency Medical Director approved self-study or directed study	Case reviews and grand rounds	Formal distance learning	Journal article review with an evaluation instrument	Author or co-author an EMS related article in a nationally recognized publication	
Pediatric Assessment and Management *(8 hrs required)*											
Anatomy and physiology											
Medical terminology											
Pathophysiology											
Life span development											
Public health											
Pharmacology											
Airway management											
Assessment											
Medical Conditions											
Shock and resuscitation											
Trauma											
Special patient populations											
EMS systems and operations *(LZO and Extrication Awareness required)*											
TOTAL hours in each Venue (add down)											

During this license cycle, I have completed and documented the following:
A minimum of two (2) hours of Extrication Awareness training Yes___ No___ Date: _____
Landing Zone Officer (LZO) training ☐Distributed learning or ☐Classroom **Yes___ No___ Date: _____**

I solemnly swear (or certify) that the information I have provided within this document including any attached supplemental information is true, complete and correct. I further understand that failing to disclose information or falsification of information may be punishable by prosecution for perjury pursuant to Section 18-5401, Idaho Code. I understand that this submission may be audited and I may be expected to produce valid documentation supporting the information I have submitted. Violations of IDAPA 16.01.12.10, "Falsification of Applications or Reports" may result in an EMS license denial, refusal to renew, suspension or revocation.

_____ _____
Candidate signature Date

Paramedic Skills Verification Candidate Name: _____

As the Physician Medical Director for the above named EMS Agency, I attest that this license renewal candidate has demonstrated proficiency in the skills and knowledge necessary to provide safe and effective patient care at the Paramedic license level and in the recognition and management of traumatic injuries and medical life threats or conditions for the pediatric, adult, geriatric and special needs populations. Furthermore, I attest to the competency of this candidate in all skills and interventions within the "floor" of the Idaho EMS Physician Commission Scope of Practice that includes:

- Advanced airway, ventilation, and oxygenation, to include endotracheal intubation
- Cardiovascular and circulation, to include cardiac rhythm interpretation
- Immobilization
- Medication administration, to include parenteral drug administration
- Normal and complicated childbirth
- Patient care reporting documentation
- Safety and transport operations
- Vascular access, and
- Manual defibrillation.

Is the scope of practice for this license renewal candidate restricted as a result of failure to meet or maintain proficiencies? Yes No

If Yes, please provide details:

_____ _____ _____

Signature of MD Printed Name Date